

Kirk T. Moss, MD., P.C.
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Date seen: 2.2.05
Patient Name: JOHN MITCHELL
Employer: _____

WORK STATUS

_____ May resume REGULAR work activities immediately.
_____ May resume MODIFIED work activities immediately.
☒ Temporarily unable to resume any work activities because such activity could place him/her or co-workers at risk.

The period of disability: FROM 2.2.05 TO 2.5.05

To be determined by referral doctor: _____

May resume REGULAR activity on: _____

May resume MODIFIED activity on: _____

_____ Presently unable to determined work date.

WORK LIMITATIONS

_____ Lifting, pushing, pulling not to exceed _____ pounds.
_____ Bending or twisting not to exceed _____ times per hour.
_____ Sitting job only. _____ No climbing or overhead work.
_____ No operation of moving equipment.
_____ Right hand work only. _____ Left hand work only.
_____ Keep wound clean and dry:

Other: _____

FOLLOW-UP CARE/REFERRAL

_____ Discharge from medical care.
_____ Return to see Dr. Moss on: _____
_____ Referred for follow-up care to: _____
_____ Appointment scheduled for: _____

Additional comments: _____

PHYSICIAN 

2.2.05
DATE

ATTACHMENT 5